New Client Consultation Form

PERSONAL DETAILS

FIRST NAME: _____ LAST NAME: _____

STREET ADDRESS: _____ CITY: _____

COUNTRY: _____ POSTCODE: _____

DATE: _____ dd / mm / yyyy DATE OF BIRTH: _____ dd / mm / yyyy

MOBILE: _____ EMAIL: _____

PREFERRED CONTACT: _____

CURRENT HEALTH

Do you have any current illnesses?

◯ No ◯ Yes

DETAILS: _____

Are you undergoing any investigations?

◯ No ◯ Yes

DETAILS: _____

Any recent, current or planned dental work?

◯ No ◯ Yes

DETAILS: _____

Do you take any medication?

◯ No ◯ Yes

DETAILS: _____

MEDICATION HISTORY

Do you take, or have you recently taken?

- ☐ Hormone replacement
- ☐ Oral contraceptives
- ☐ Aspirin/NSAIDs
- ☐ St John's Wort
- ☐ Vitamin E
- ☐ Antico-agulants
- ☐ Roaccutane
- ☐ Antibiotics

Details

ALLERGIES

Do you have any allergies?

◯ No ◯ Yes

Do you have a history of severe allergic reaction or anaphylaxis?

◯ No ◯ Yes

Do you have a history of severe allergic reaction or anaphylaxis?

◯ No ◯ Yes

Have you had adverse reaction to aesthetic treatment in the past?

◯ No ◯ Yes

Details

MEDICAL HISTORY

Do you have a history of any of the following?

- ☐ Angina / Heart Disease
- ☐ Auto-immune Disorder
- ☐ Liver / Kidney Disease
- ☐ Head-aches / Migraine
- ☐ Myaesthenia Travis
- ☐ Facial Palsy
- ☐ Keloid Scarring
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Acne
- ☐ Fainting
- ☐ Cosmetic Surgery
- ☐ Blood Clots
- ☐ Cold sores
- ☐ Low / High BP
- ☐ Thyroid Disorder
- ☐ Eaton-Lambert
- ☐ HIV / Hepatitis
- ☐ Rheumatic Fever
- ☐ Asthma / COPD
- ☐ CVA
- ☐ Skin Infection
- ☐ Eczema / psoriasis
- ☐ Convulsions / Epilepsy
- ☐ Other

Details

LIFESTYLE

Do you take regular exercise?

◯ No ◯ Yes

Details: _____

Do you or have you ever smoked?

◯ No ◯ Yes

Details: _____

Do you drink alcohol?

◯ No ◯ Yes

Details: _____

Do you have a balanced diet?

◯ No ◯ Yes

Details: _____

Are you pregnant or trying to conceive?

◯ No ◯ Yes

Details: _____

Are you breast feeding?

◯ No ◯ Yes

Details: _____

Do you use sunbeds?

◯ No ◯ Yes

Details: _____

Do you have any planned vacations?

◯ No ◯ Yes

Details: _____

Do you use daily SPF?

◯ No ◯ Yes

Details: _____

What skincare products do you use?

◯ No ◯ Yes

Details: _____

Have you used retinol in last 2 months?

◯ No ◯ Yes

Details: _____

Do you have any permanent or semi permanent make up?

◯ No ◯ Yes

Details: _____

Are you needle phobic?

◯ No ◯ Yes

Details: _____

Are you prone to bruising?

◯ No ◯ Yes

Details: _____

Do you have any social events in the near future?

◯ No ◯ Yes

Details: _____

Are you able to attend for review in 2 weeks?

◯ No ◯ Yes

Details: _____

AESTHETIC HISTORY

Please provided details of recent aesthetic treatments.

What: _____ **When:** _____

Where: _____

GOALS AND EXPECTATIONS

What are your main areas of concern?

What are your expectations following treatment?

ADDITIONAL NOTES

DECLARATION

I confirm that the information I have given is correct.

FIRST NAME: _____ **LAST NAME:** _____

SIGNATURE

DATE: _____ dd / mm / yyyy

PRACTITIONER SIGNATURE